

907 KAR 3:015. Supplemental payments for certain primary care and vaccines.

RELATES TO: KRS 205.520, 205.560

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1), 42 U.S.C. 1395l, 42 U.S.C. 1395w-4(c)(2)(B), 42 C.F.R. 447.400, 42 C.F.R. 447.405, 42 C.F.R. 447.410, 42 C.F.R. 447.415

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the policies and requirements regarding Medicaid program supplemental payments for certain primary care services and vaccines in accordance with Title V, Subtitle F, Section 5501 of the Affordable Care Act (42 U.S.C. 1395l and 42 U.S.C. 1395w-4(c)(2)(B)), 42 C.F.R. 447.405, 42 C.F.R. 447.410, and 42 C.F.R. 447.415.

Section 1. Definitions. (1) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(2) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Eligible evaluation and management service" means a service:

(a) Which qualifies for supplemental reimbursement in accordance with Section 3(1)(a), (b), and (c)1. of this administrative regulation; and

(b) For which there is a corresponding paid claim.

(5) "Eligible provider" means a provider who qualifies for supplemental reimbursement in accordance with Section 2 of this administrative regulation.

(6) "Eligible vaccine" means a vaccine:

(a) Which qualifies for supplemental reimbursement in accordance with Section 3(1)(a), (b) and (c)2. of this administrative regulation; and

(b) For which there is a corresponding paid claim.

(7) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(8) "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(10) "Medicaid program" means Kentucky's program of services and benefits covered by the Department for Medicaid Services or managed care organizations.

(11) "Personal supervision" means being professionally responsible for the services rendered by an advanced practice registered nurse or a physician assistant.

(12) "Physician" is defined by KRS 311.550(12).

(13) "Physician assistant" is defined by KRS 311.840(3).

(14) "Provider" is defined by KRS 205.8451(7).

(15) "Recipient" is defined in KRS 205.8451(9).

Section 2. Conditions to Qualify for Supplemental Reimbursement for Primary Care Services and Vaccines. (1) To qualify for a supplemental payment, a provider shall:

(a) Be currently enrolled with the Medicaid program in accordance with 907 KAR 1:672;

(b)1. Be currently participating in the Medicaid program in accordance with 907 KAR 1:671; and

2. Comply with 907 KAR 1:671;
- (c) Be a primary care physician practicing in one (1) of the following areas:
 1. Family medicine;
 2. General internal medicine; or
 3. Pediatric medicine; and
- (d) Attest to being a primary care physician and to one (1) of the following:
 1. Currently having board certification as a primary care physician by the:
 - a. American Board of Medical Specialties;
 - b. American Board of Physician Specialties; or
 - c. American Osteopathic Association;
 2. Unless a newly eligible physician or physician without a prior billing history, having provided the following evaluation and management services or vaccines in an amount that equals at least sixty (60) percent of Medicaid codes billed to the Medicaid program during the most recently completed calendar year:
 - a. Evaluation and management CPT codes:
 - (i) Within the range of 99201 through 99499; and
 - (ii) That are covered by the department in accordance with 907 KAR 3:010; or
 - b. Vaccine codes which are covered by the department in accordance with 907 KAR 1:680 (regardless of the age of the recipient) or 907 KAR 3:010;
 3. If a newly eligible physician, having provided the services or vaccines referenced in subparagraph 2a or 2b of this paragraph in an amount that equals at least sixty (60) percent of Medicaid codes billed to the Medicaid program during the prior month; or
 4. Being an eligible primary care physician:
 - a. Without a billing history; and
 - b. For whom sixty (60) percent of total Medicaid billings shall be of codes referenced in subparagraph 2a or 2b of this paragraph.
- (2) Services or vaccines which meet the qualifying criteria in Section 3 of this administrative regulation and which are provided by a physician assistant or advanced practice registered nurse working under the personal supervision of a qualifying primary care physician shall qualify for the supplemental reimbursement.

Section 3. Supplemental Reimbursement for Primary Care Services and Vaccines. (1) Supplemental reimbursement shall be made, as established in subsections (2) and (3) of this section, for providing a service or vaccine:

- (a) On a day on or after January 1, 2013 until midnight December 31, 2014:
 1. To a recipient; and
 2. By a:
 - a. Provider who qualifies for the supplemental reimbursement pursuant to Section 2 of this administrative regulation; or
 - b. An APRN or a physician assistant working under the personal supervision of a primary care physician who qualifies for the supplemental reimbursement pursuant to Section 2 of this administrative regulation;
- (b) That is medically necessary for the given recipient; and
- (c) That is:
 1. An evaluation and management service which:
 - a. Corresponds to a CPT code within the range of 99201 through 99499; and
 - b. Is currently covered by the department in accordance with 907 KAR 3:010; or
 2. Billed using a vaccine code which is covered by the department in accordance with 907 KAR 1:680 (regardless of the age of the recipient) or 907 KAR 3:010.

(2)(a) For a given quarter of paid claims associated with eligible evaluation and management services provided by an eligible provider to recipients who were not enrolled in a managed care organization and for which:

1. DMS had an established rate as of July 1, 2009, the department shall make a lump sum payment that represents the difference between:

a. The DMS established rates as of July 1, 2009 for the claims in aggregate for the quarter; and
b. What the provider would have received for the same paid claims in aggregate for the same quarter if the provider's reimbursement for the claims had been the amount established in 42 C.F.R. 447.405(a); or

2. DMS did not have an established rate as of July 1, 2009, but established a rate prior to January 1, 2013, the department shall make a lump sum payment that represents the difference between:

a. The DMS established rates as of December 31, 2012 for the claims in aggregate for the quarter; and

b. What the provider would have received for the same paid claims in aggregate for the same quarter if the provider's reimbursement for the claims had been the amount established in 42 C.F.R. 447.405(a).

(b) For a given quarter of paid claims associated with eligible vaccines provided by an eligible provider to recipients who were not enrolled in a managed care organization and for which:

1. DMS had an established rate as of July 1, 2009, the department shall make a lump sum payment that represents the difference between:

a. The DMS established rates as of July 1, 2009 for the claims in aggregate for the quarter; and
b. What the provider would have received for the same paid claims in aggregate for the same quarter if the provider's reimbursement for the claims had been the amount established in 42 C.F.R. 447.405(b); or

2. DMS did not have an established rate as of July 1, 2009, but established a rate prior to January 1, 2013, the department shall make a lump sum payment that represents the difference between:

a. The DMS established rates as of December 31, 2012 for the claims in aggregate for the quarter; and

b. What the provider would have received for the same paid claims in aggregate for the same quarter if the provider's reimbursement for the claims had been the amount established in 42 C.F.R. 447.405(b).

(3)(a) For a given quarter of paid claims associated with eligible evaluation and management services provided by all eligible providers to recipients who were enrolled in a given managed care organization, the:

1. Department shall send funds to the managed care organization representing the aggregate supplemental reimbursement amount for the paid claims; and

2. Managed care organization shall:

a. Within fifteen (15) business days of receiving the funds referenced in subparagraph 1. of this paragraph, supplement reimbursement to each eligible provider in an amount determined using the methodology described in subsection (2)(a) of this section; and

b. Submit documentation to the department demonstrating that the supplemental reimbursement referenced in subparagraph 1 of this paragraph was made to all eligible providers for the corresponding quarter.

(b) For a given quarter of paid claims associated with eligible vaccines provided by all eligible providers to recipients who were enrolled in a given managed care organization, the:

1. Department shall send funds to the managed care organization representing the aggregate supplemental reimbursement amount for the paid claims; and

2. Managed care organization shall:

- a. Within fifteen (15) business days of receiving the funds referenced in subparagraph 1 of this paragraph, supplement reimbursement to each eligible provider in an amount determined using the methodology described in subsection (2)(b) of this section; and
- b. Submit documentation to the department demonstrating that the supplemental reimbursement referenced in subparagraph 1 of this paragraph was made to all eligible providers for the corresponding quarter.

Section 4. Applicability. (1) The policies and requirements established in this administrative regulation shall govern supplemental payments for certain primary care services and vaccines in accordance with Title V, Subtitle F, Section 5501 of the Affordable Care Act (42 U.S.C. 1395l and 42 U.S.C. 1395w-4(c)(2)(B)), 42 C.F.R. 447.400, 42 C.F.R. 447.405, 42 C.F.R. 447.410, and 42 C.F.R. 447.415.

(2) Any policy or requirement regarding payments for physician or primary care services or vaccines established in any other administrative regulation within Title 907 of the Kentucky Administrative Regulations shall not apply to the supplemental payments referenced in subsection (1) of this section.

Section 5. Auditing. (1) A provider shall be subject to departmental review or audit.

(2) The department shall be authorized to take action regarding fraud or abuse in accordance with:

- (a) 907 KAR 1:671; or
- (b) KRS 205.8453.

Section 6. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

- (1) Denies or does not provide federal financial participation for the policy; or
- (2) Disapproves the policy. (39 Ky.R. 2284; 40 Ky.R. 19; eff. 8-2-2013.)